



Editorial

Syndemics, Habitus, and the Moral Worlds of Diseases in South Asia

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Introduction

In the first half of 2026, most South Asian countries reported outbreaks of various infectious diseases, including measles, malaria, HIV, dengue, chikungunya, and emerging zoonotic infections such as Nipah virus. These outbreaks across Pakistan, Sri Lanka, Bangladesh, India, and Nepal are not isolated incidents but rather patterned recurrences influenced by shared regional conditions shaped by similar “critical events” in both the past and the present (Das 1995). In this editorial, we argue that understanding these patterns and practices requires a holistic approach that benefits from the dual concepts of “syndemics” and “habitus” (see Dahdah et al., 2022). Syndemics, a term introduced by Singer (2000), describes how multiple diseases co-occur and biosocially interact, particularly in communities facing deep systemic inequities. Building on Bourdieu (2008), habitus refers to how people's habits, dispositions, and social norms become deeply internalized and persist in daily life. In this regard,

sociocultural perceptions and practices about illness—such as attributing disease to fate, divine punishment, or tests of faith—contribute to the spread and social acceptance of these conditions (Ali 2023).

In Pakistan, the concurrent outbreaks of measles, endemic malaria, and an escalating pediatric HIV epidemic reflect the profound interconnectedness of sociocultural, political, and economic disparities that shape health outcomes. Similar patterns are evident in Bangladesh, where recurrent dengue epidemics and a resurgence of measles predominantly affect densely populated urban centres that have been transformed by rapid, unplanned urbanisation. Sri Lanka, often lauded for relatively stronger health indicators, continues to grapple with cyclical waves of dengue, chikungunya, and measles—phenomena deeply intertwined with climatic variability and ecological shifts (Ali et al. 2025). Extending beyond these nations, recent regional developments further illuminate the syndemic nature of disease, revealing how social mobility,

ecological change, and entrenched inequalities create a web of interconnected health crises. In Nepal, measles outbreaks predominantly affect marginalised, under-vaccinated communities, often linked to cross-border movements and structural immunisation gaps. Meanwhile, in India and Bangladesh, cases of Nipah virus reveal the intricate entanglement of ecological interfaces, sociocultural practices, and biological factors. These examples demonstrate that South Asia functions less as a collection of isolated epidemiological episodes and more as an interwoven syndemic landscape, where mobility, environmental dynamics, and systemic inequities perpetuate interconnected health vulnerabilities (Farmer 1996).

Crucially, infectious diseases do not exist in a vacuum in South Asia; a heavy burden of non-communicable diseases (NCDs)—such as diabetes, hypertension, kidney disease, hepatitis, and tuberculosis—also afflicts the region. We argue that these infectious outbreaks interact dynamically with pre-existing chronic conditions rather than acting in isolation. Such interactions produce compounded, critical health outcomes, particularly within fragile health systems that have historically struggled to manage overlapping epidemiological transitions (Jackson-Morris et al., 2024). These biological interactions are further intensified by socioeconomic realities such as poverty, precarious livelihoods, malnutrition, and limited healthcare access, which disproportionately burden vulnerable populations. In this sense, the syndemic lens encompasses more than just co-occurring infectious diseases; it captures the convergence of infectious and non-communicable conditions within landscapes of inequity (Yadav et al., 2020). This biosocial entanglement is sharply visible in localised contexts, such as the documented syndemic clustering of diabetes, chronic kidney disease, and viral susceptibility within Pakistan's structurally neglected communities (Ali, 2021). These social conditions create

environments that allow multiple diseases not only to cluster but also to actively reinforce one another.

However, to fully understand why these conditions persist, it is necessary to move beyond structural analysis and examine how these realities are lived, interpreted, and normalised. The concept of *habitus* offers critical insight here, denoting the internalised dispositions through which individuals perceive and navigate their social worlds. In contexts where disease is recurrent and healthcare access is uncertain, communities develop ways of understanding illness that align with their lived realities. Across South Asia, illness is often interpreted not only through biomedical frameworks but also through moral and supernatural logics, viewed as fate, destiny, or a spiritual test. These interpretations are not marginal; they are central to how “social suffering” (Kleinman, Das, and Lock 1997) is made meaningful.

Such moral framings serve important social and psychological functions: they provide coherence in uncertain contexts, enable endurance in the face of structural neglect, and situate illness within broader cosmologies of meaning. Yet, they also inadvertently contribute to the normalisation of disease. When outbreaks of infectious diseases such as measles, dengue, or malaria are understood as inevitable whether due to seasonal cycles or divine will—they risk becoming embedded in the taken-for-granted fabric of everyday life. This normalisation does not imply passivity or ignorance; instead, it reflects the severe structural constraints under which people operate. When structural conditions limit access to timely and effective healthcare, interpreting illness as fate may be one of the few ways to reconcile oneself to suffering. Nonetheless, when such interpretations intersect with persistent inequities, they can sustain a cycle in which disease is expected rather than contested.

The combination of syndemics and habitus thus offers a comprehensive framework for studying the structural inequities that enable multiple diseases to coexist and interact, while simultaneously illuminating the sociocultural normalisation that blunts the impetus for systemic change. This dynamic is further compounded by what might be described as a policy-level “politics of optimism” (Closser 2010), in which partial public health successes are overemphasised while deeper structural vulnerabilities remain unaddressed. Resolving this critical situation requires a serious, dual engagement with both approaches. It calls for recognising that diseases are not merely biological phenomena but are deeply embedded in social relations, cultural meanings, and moral worlds. Public and global health interventions that overlook these dimensions risk failing because they misalign with how communities actually experience and interpret illness. Across South Asia, addressing recurrent outbreaks requires more than technical or biomedical fixes; it demands dismantling the syndemic conditions that link disease to inequity, while actively engaging with the habitus that shapes everyday survival.

In conclusion, we emphasise that the persistent outbreaks of infectious diseases in South Asia cannot be attributed solely to pathogen traits or policy failures. Instead, they reveal deeply rooted, historically embedded patterns of inequity and cultural meaning-making. By adopting the frameworks of syndemics and habitus, we advocate a critical shift in public health strategies—one that recognises disease as a product of intricate biological, sociocultural, economic, geopolitical, and environmental interactions. Recognising and addressing the normalisation of disease processes is as crucial as halting its biological transmission if we are to achieve a truly holistic approach to regional health.

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